COMMUNITY FIRST CHOICE/PERSONAL ASSISTANCE SERVICES
RECERTIFICATION DOCUMENTATION

☐ CFC-AB ☐ CFC-SD ☐ PAS-AB ☐ PAS-SD

Member Name: _____ Medicaid ID#: _____

Contact Person (if applicable): _____ Date of Visit: _____

Member average biweekly utilization in units (1 unit = 15 minutes) for the previous two months: _____
Current Authorization _____

"No" Answers require an action plan. All issues identified through this review process require an action plan.

Member overview, Profile and Service Plan have been reviewed with the member/PR: ☐ Yes ☐ No
Comments:

Service Delivery Records appropriately reflect the Service Plan ☐ Yes ☐ No
Comments:

Current profile and service plan are meeting member's needs ☐ Yes ☐ No
Comments:

AGENCY ACTION PLAN *(address issues identified above as well as identified compliance issues):*

☐ *Self-Direct Only:* Compliance Form Completed. Refer to attached document.

Additional Comments*:*

Member/PR (self-direct) or Agency (agency based) evaluation of attendants

Displays competence and safety in performing tasks: ☐ Yes ☐No	Attendant present at visit ☐Yes ☐No (doesn't require action plan)
Performs tasks according to duty guide and policy: ☐ Yes ☐No	Attendant name:
Interaction and performance is satisfactory: ☐ Yes ☐No	Additional training need identified:

Agency Signature: _____Agency: _____ Date: _____

My signature below indicates that I have been offered voluntary training on the management of personal care attendants.

Member/PR Signature: _____ Date: _____

Distribution: White-Provider; Yellow-Member